This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.eugene-or.gov/employeebenefits or by calling 541-682-5062.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$150 person / $450 family Doesn't apply to preventive care, services due to accidental injury, outpatient surgery physician/facility charges, and routine exams/hardware under vision plan. Combined deductible for medical and pharmacy.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Dental care other than preventative care: Individual $50 / Family $150. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. $1,000 person	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, mail-order pharmacy co-pays, deductibles, balanced-billed charges, dental benefits and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see PacificSource.com or call 1-888-977-9299 for medical/vision/pharmacy, or see ODScompanies.com or call 1-888-217-2365 for dental.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 541-682-5062 or visit us at www.eugene-or.gov/employeebenefits.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 541-682-5062 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	50% co-insurance	---none---
	Specialist visit	20% co-insurance	50% co-insurance	---none---
	Other practitioner office visit Acupuncture Chiropractic Care Massage Therapy Naturopath	 20% co-insurance 20% co-insurance 20% co-insurance 20% co-insurance	 20% co-insurance 20% co-insurance 20% co-insurance 20% co-insurance	 ---none--- Chiropractic care limited to 52 visits/year. Massage Therapy limited to $300/year. Naturopath limited to $300/year. No coverage for naturopathic and homeopathic remedies and prescriptions.
	Preventive care/screening/immunization Routine Physicals Well Baby/Child Visit Routine Gynecological Exam Tobacco Cessation Immunizations Preventive Colonoscopy	 20% co-insurance 20% co-insurance 20% co-insurance No charge 20% co-insurance 20% co-insurance	 50% co-insurance 50% co-insurance 50% co-insurance No charge 50% co-insurance 50% co-insurance	Limited to: Routine Physicals/Well Baby: no visit max ages 0-12 months, 2 per year ages 1-2, and annually ages 2 and older. Routine Gynecological Exam: annually. Tobacco Cessation: age 15 or older up to $500 lifetime max. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	---none---

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available www.PacificSource.com.	Generic drugs	Retail:$10 co-pay Mail: $10 co-pay	Same as participating	Retail day supply unlimited. Mail limited to 90-day supply. Pre-auth req'd for certain drugs. Retail drugs subject to medical deductible of $150 person/$450 family and medical out-of-pocket limit of $1,000/year. Once out-of-pocket limit reached, co-pays for drugs obtained from a participating retail pharmacy are waived for the remainder of year. Differential between generic and brand drugs, and non-participating retail pharmacy charges do not apply to the out-of-pocket limit.
	Preferred brand drugs	Retail: 20% co-insurance Mail: $20 co-pay or 20% co- insurance, whichever is greater ($30 max co-pay)	Same as participating	
	Non-preferred brand drugs	Retail: 25% co-insurance Mail: $25 co-pay or 25% co-insurance, whichever is greater ($60 max co-pay)	Same as participating	
	Specialty drugs	Same as retail	Same as participating	Coverage available only through our specialty pharmacy services provider. Limited to 30-day supply. Pre-auth req'd for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	50% co-insurance	---none---
	Physician/surgeon fees	20% co-insurance	50% co-insurance	---none---
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation Ground Ambulance Air Ambulance	 20% co-insurance 20% co-insurance	 20% co-insurance 20% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	20% co-insurance	50% co-insurance	---none---

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Pre-auth req'd for inpatient elective surgery.
	Physician/surgeon fee	20% co-insurance	50% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	20% co-insurance	---none---
	Mental/Behavioral health inpatient services	20% co-insurance	20% co-insurance	Pre-auth req'd.
	Substance use disorder outpatient services	20% co-insurance	20% co-insurance	---none---
	Substance use disorder inpatient services	20% co-insurance	20% co-insurance	Pre-auth req'd.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	50% co-insurance	---none---
	Delivery and all inpatient services	20% co-insurance	50% co-insurance	Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services.
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	Limited to 100 four-hour visits/year. Pre-auth req'd. No coverage for private duty nursing.
	Rehabilitation services Inpatient Outpatient	 20% co-insurance 20% co-insurance	 50% co-insurance 20% co-insurance	 Pre-auth req'd. Pre-auth req'd. No coverage for recreation therapy.
	Habilitation services Inpatient Outpatient	 20% co-insurance 20% co-insurance	 50% co-insurance 20% co-insurance	 Pre-auth req'd. Pre-auth req'd. No coverage for recreation therapy.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	50% co-insurance	50% co-insurance	Limited to 60 days/calendar year. Pre-auth req'd. No coverage for custodial care.
	Durable medical equipment	20% co-insurance	20% co-insurance	Must be prescribed by physician; rental covered up to rental equipment purchase price when prescribed by physician; hearing aids for children limited to $4,000 per 48 months; hearing aids for adults limited to $500 per 36 months and requires 50% co-insurance for participating and non-participating providers. Pre-auth req'd over $800.
	Hospice service	No charge	No charge	Pre-auth req'd for inpatient hospice. No coverage for private duty nursing.
If your child needs dental or eye care	Eye exam	20% co-insurance	20% co-insurance	Limited to one exam per 12 months, up to $60.
	Glasses	No charge	No charge	Every 24 months limited to: Per lens: $20 single vision, $30 bifocal, $40 trifocal, $60 lenticular; frames: $50 per pair.
	Dental check-up	No charge	No charge	Plan pays 100% preventative examinations every 6 months. Benefit is limited to $250 per person for expenses incurred first calendar year of eligibility; $1,250 per person each calendar year thereafter.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Custodial care
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Outpatient recreational therapy
- Private duty nursing
- Routine foot care, other than with diabetes mellitus

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Naturopath
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-977-9299. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the PacificSource Customer Service Department at 1-888-977-9299. For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Oregon Insurance Division's Consumer Advocacy Unit at 1-503-947-7984 or toll-free at 1-888-877-4894.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-977-9299.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers:	$7,540
Plan pays	$6,440
Patient pays	$1,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$0
Coinsurance	$900
Limits or exclusions	$0
Total	**$1,100**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers:	$5,400
Plan pays	$4,260
Patient pays	$1,140

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$400
Coinsurance	$500
Limits or exclusions	$40
Total	**$1,140**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-888-977-9299.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.